

(i) shared savings and competitive bidding in FFS Medicare;

(ii) use of MA-negotiated rates to set FFS Medicare rates; and

(iii) novel approaches to information development and sharing that may enable markets to lower cost and improve quality for FFS Medicare beneficiaries.

SEC. 10. *Reducing Obstacles to Improved Patient Care.* Within 1 year of the date of this order, the Secretary shall propose regulatory changes to the Medicare program to reduce the burden on providers and eliminate regulations that create inefficiencies or otherwise undermine patient outcomes.

SEC. 11. *Maximizing Freedom for Medicare Patients and Providers.* (a) Within 180 days of the date of this order, the Secretary, in coordination with the Commissioner of Social Security, shall revise current rules or policies to preserve the Social Security retirement insurance benefits of seniors who choose not to receive benefits under Medicare Part A, and propose other administrative improvements to Medicare enrollment processes for beneficiaries.

(b) Within 1 year of the date of this order, the Secretary shall identify and remove unnecessary barriers to private contracts that allow Medicare beneficiaries to obtain the care of their choice and facilitate the development of market-driven prices.

SEC. 12. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

§ 1395. Prohibition against any Federal interference

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

(Aug. 14, 1935, ch. 531, title XVIII, § 1801, as added Pub. L. 89-97, title I, § 102(a), July 30, 1965, 79 Stat. 291.)

Statutory Notes and Related Subsidiaries

SHORT TITLE

For short title of title I of Pub. L. 89-97, which enacted this subchapter as the “Health Insurance for the Aged Act”, see section 100 of Pub. L. 89-97, set out as a Short Title of 1965 Amendment note under section 1305 of this title.

PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS

Pub. L. 111-148, title III, § 3601, Mar. 23, 2010, 124 Stat. 538, provided that:

“(a) PROTECTING GUARANTEED MEDICARE BENEFITS.—Nothing in the provisions of, or amendments made by,

this Act [see Short Title note set out under section 1801 of this title] shall result in a reduction of guaranteed benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

“(b) ENSURING THAT MEDICARE SAVINGS BENEFIT THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES.—Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.”

§ 1395a. Free choice by patient guaranteed

(a) Basic freedom of choice

Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services.

(b) Use of private contracts by medicare beneficiaries

(1) In general

Subject to the provisions of this subsection, nothing in this subchapter shall prohibit a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or service—

(A) for which no claim for payment is to be submitted under this subchapter, and

(B) for which the physician or practitioner receives—

(i) no reimbursement under this subchapter directly or on a capitated basis, and

(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this subchapter directly or on a capitated basis.

(2) Beneficiary protections

(A) In general

Paragraph (1) shall not apply to any contract unless—

(i) the contract is in writing and is signed by the medicare beneficiary before any item or service is provided pursuant to the contract;

(ii) the contract contains the items described in subparagraph (B); and

(iii) the contract is not entered into at a time when the medicare beneficiary is facing an emergency or urgent health care situation.

(B) Items required to be included in contract

Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the medicare beneficiary that by signing such contract the beneficiary—

(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this subchapter for such items or services even if such items or services are otherwise covered by this subchapter;

(ii) agrees to be responsible, whether through insurance or otherwise, for pay-

ment of such items or services and understands that no reimbursement will be provided under this subchapter for such items or services;

(iii) acknowledges that no limits under this subchapter (including the limits under section 1395w-4(g) of this title) apply to amounts that may be charged for such items or services;

(iv) acknowledges that Medigap plans under section 1395ss of this title do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made under this subchapter; and

(v) acknowledges that the medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this subchapter.

Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the medicare program under section 1320a-7 of this title.

(3) Physician or practitioner requirements

(A) In general

Paragraph (1) shall not apply to any contract entered into by a physician or practitioner unless an affidavit described in subparagraph (B) is in effect during the period any item or service is to be provided pursuant to the contract.

(B) Affidavit

An affidavit is described in this subparagraph if—

(i) the affidavit identifies the physician or practitioner and is in writing and is signed by the physician or practitioner;

(ii) the affidavit provides that the physician or practitioner will not submit any claim under this subchapter for any item or service provided to any medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) during the applicable 2-year period (as defined in subparagraph (D)); and

(iii) a copy of the affidavit is filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

(C) Enforcement

If a physician or practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim under this subchapter for any item or service provided during the applicable 2-year period (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—

(i) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and

(ii) no payment shall be made under this subchapter for any item or service fur-

nished by the physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in paragraph (1)(B) shall be made for any such item or service).

(D) Applicable 2-year periods for effectiveness of affidavits

In this subsection, the term “applicable 2-year period” means, with respect to an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed and includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.

(4) Limitation on actual charge and claim submission requirement not applicable

Section 1395w-4(g) of this title shall not apply with respect to any item or service provided to a medicare beneficiary under a contract described in paragraph (1).

(5) Posting of information on opt-out physicians and practitioners

(A) In general

Beginning not later than February 1, 2016, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health and Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

(B) Information to be included

The information to be made available under subparagraph (A) shall include at least the following with respect to opt-out physicians and practitioners:

(i) Their number.

(ii) Their physician or professional specialty or other designation.

(iii) Their geographic distribution.

(iv) The timing of their becoming opt-out physicians and practitioners, relative, to the extent feasible, to when they first enrolled in the program under this subchapter and with respect to applicable 2-year periods.

(v) The proportion of such physicians and practitioners who billed for emergency or urgent care services.

(6) Definitions

In this subsection:

(A) Medicare beneficiary

The term “medicare beneficiary” means an individual who is entitled to benefits under part A or enrolled under part B.

(B) Physician

The term “physician” has the meaning given such term by paragraphs (1), (2), (3), and (4) of section 1395x(r) of this title.

(C) Practitioner

The term “practitioner” has the meaning given such term by section 1395u(b)(18)(C) of this title.

(D) Opt-out physician or practitioner

The term “opt-out physician or practitioner” means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).

(Aug. 14, 1935, ch. 531, title XVIII, § 1802, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 291; amended Pub. L. 105–33, title IV, § 4507(a)(1), (2)(A), Aug. 5, 1997, 111 Stat. 439, 441; Pub. L. 108–173, title VI, § 603, Dec. 8, 2003, 117 Stat. 2301; Pub. L. 114–10, title I, § 106(a)(1)(A), (2), Apr. 16, 2015, 129 Stat. 137, 138.)

Editorial Notes**AMENDMENTS**

2015—Subsec. (b)(3)(B)(ii). Pub. L. 114–10, § 106(a)(1)(A)(i), substituted “during the applicable 2-year period (as defined in subparagraph (D))” for “during the 2-year period beginning on the date the affidavit is signed”.

Subsec. (b)(3)(C). Pub. L. 114–10, § 106(a)(1)(A)(ii), substituted “during the applicable 2-year period” for “during the 2-year period described in subparagraph (B)(ii)” in introductory provisions.

Subsec. (b)(3)(D). Pub. L. 114–10, § 106(a)(1)(A)(iii), added subpar. (D).

Subsec. (b)(5). Pub. L. 114–10, § 106(a)(2)(C), added par. (5). Former par. (5) redesignated (6).

Subsec. (b)(5)(D). Pub. L. 114–10, § 106(a)(2)(A), added subpar. (D).

Subsec. (b)(6). Pub. L. 114–10, § 106(a)(2)(B), redesignated par. (5) as (6).

2003—Subsec. (b)(5)(B). Pub. L. 108–173 substituted “paragraphs (1), (2), (3), and (4) of section 1395x(r)” for “section 1395x(r)(1)”.

1997—Pub. L. 105–33 designated existing provisions as subsec. (a), inserted heading, and added subsec. (b).

Statutory Notes and Related Subsidiaries**EFFECTIVE DATE OF 2015 AMENDMENT**

Pub. L. 114–10, title I, § 106(a)(1)(B), Apr. 16, 2015, 129 Stat. 138, provided that: “The amendments made by subparagraph (A) [amending this section] shall apply to affidavits entered into on or after the date that is 60 days after the date of the enactment of this Act [Apr. 16, 2015].”

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, § 4507(c), Aug. 5, 1997, 111 Stat. 442, provided that: “The amendment made by subsection (a) [amending this section and section 1395y of this title] shall apply with respect to contracts entered into on and after January 1, 1998.”

UPDATING THE WELCOME TO MEDICARE PACKAGE

Pub. L. 114–255, div. C, title XVII, § 17003, Dec. 13, 2016, 130 Stat. 1331, provided that:

“(a) IN GENERAL.—Not later than 12 months after the last day of the period for the request of information described in subsection (b), the Secretary of Health and Human Services shall, taking into consideration information collected pursuant to subsection (b), update the information included in the Welcome to Medicare package to include information, presented in a clear and simple manner, about options for receiving benefits under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including through the original Medicare fee-for-service program under parts A and B of such title (42 U.S.C. 1395c et

seq., 42 U.S.C. 1395j et seq.), Medicare Advantage plans under part C of such title (42 U.S.C. 1395w–21 et seq.), and prescription drug plans under part D of such title (42 U.S.C. 1395w–101 et seq.). The Secretary shall make subsequent updates to the information included in the Welcome to Medicare package as appropriate.

“(b) REQUEST FOR INFORMATION.—Not later than 6 months after the date of the enactment of this Act [Dec. 13, 2016], the Secretary of Health and Human Services shall request information, including recommendations, from stakeholders (including patient advocates, issuers, and employers) on information included in the Welcome to Medicare package, including pertinent data and information regarding enrollment and coverage for Medicare eligible individuals.”

REPORT TO CONGRESS ON EFFECT OF PRIVATE CONTRACTS

Pub. L. 105–33, title IV, § 4507(b), Aug. 5, 1997, 111 Stat. 441, required a report to be submitted to Congress, no later than Oct. 1, 2001, on the effect on the program under title IV of Pub. L. 105–33 of certain private contracts.

§ 1395b. Option to individuals to obtain other health insurance protection

Nothing contained in this subchapter shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

(Aug. 14, 1935, ch. 531, title XVIII, § 1803, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 291.)

Statutory Notes and Related Subsidiaries**IMPACT OF INCREASED INVESTMENTS IN HEALTH RESEARCH ON FUTURE MEDICARE COSTS**

Pub. L. 105–78, title II, Nov. 13, 1997, 111 Stat. 1484, provided in part: “That in carrying out its legislative mandate, the National Bipartisan Commission on the Future of Medicare shall examine the impact of increased investments in health research on future Medicare costs, and the potential for coordinating Medicare with cost-effective long-term care services”.

NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE

Pub. L. 105–33, title IV, § 4021, Aug. 5, 1997, 111 Stat. 347, established National Bipartisan Commission on the Future of Medicare which was directed to review and analyze long-term financial condition of medicare program, identify problems that threaten financial integrity of Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund, analyze potential solutions that will ensure both financial integrity of medicare program and provision of appropriate benefits under such program, and make recommendations for, among other things, restoring solvency of Federal Hospital Insurance Trust Fund and financial integrity of Federal Supplementary Medical Insurance Trust Fund, establishing appropriate financial structure of medicare program as a whole, and establishing appropriate balance of benefits covered and beneficiary contributions to medicare program, further provided for membership of Commission, meetings, personnel and staff matters, powers of Commission, appropriations, submission of final report to Congress not later than Mar. 1, 1999, and termination of Commission 30 days after submission of final report.

EXCLUSION FROM WAGES AND COMPENSATION OF RE-FUNDS REQUIRED FROM EMPLOYERS TO COMPENSATE FOR DUPLICATION OF MEDICARE BENEFITS BY HEALTH CARE BENEFITS PROVIDED BY EMPLOYERS

Pub. L. 101–239, title X, § 10202, Dec. 19, 1989, 103 Stat. 2473, provided that: